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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **LISA RENEE ALLEN** **aka Lisa Renee Pettit** **aka Lisa Todd** **aka Lisa Rock** 289C San Benancio Road Salinas, CA 93908 **Registered Nurse License No. 491867** Respondent.	Case No. 2012- 726 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN (Complainant) brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about August 31, 1993, the Board of Registered Nursing issued Registered Nurse License Number 491867 to Lisa Renee Allen, aka Lisa Renee Pettit, aka Lisa Todd, aka Lisa Rock (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on September 9, 2012, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing (Board), Department of Consumer Affairs, under the authority of the following laws. All section

references are to the Business and Professions Code unless otherwise indicated.

4. Section **2750** of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section **2764** of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

STATUTORY AND REGULATORY PROVISIONS

6. Section **2761** of the Code states, in pertinent part:

The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct . . . .

. . .

7. Section **2762** of the Code states, in pertinent part:

In addition to other acts constituting unprofessional conduct within the meaning of this chapter it is unprofessional conduct for a person licensed under this chapter to do any of the following:

(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . .

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section.

DANGEROUS DRUGS/CONTROLLED SUBSTANCES

8. Section **4021** of the Code states:

"Controlled substance" means any substance listed in Chapter 2 (commencing with Section 11053) of Division 10 of the Health and Safety Code.

9. Section **4022** of the Code states:

"Dangerous drug" or "dangerous device" means any drug or device unsafe for self-use, except veterinary drugs that are labeled as such, and includes the following:

(a) Any drug that bears the legend: "Caution: federal law prohibits dispensing without prescription," "Rx only," or words of similar import.

(b) Any device that bears the statement: "Caution: federal law restricts this device to sale by or on the order of a _____," "Rx only," or words of similar import, the blank to be filled in with the designation of the practitioner licensed to use or order use of the device.

(c) Any other drug or device that by federal or state law can be lawfully dispensed only on prescription or furnished pursuant to Section 4006."

10. **Diphenhydramine** is an antihistamine and an anticholinergic with sedative properties. In its injectible form, it is a dangerous drug as defined by Business and Professions Code section 4022.

COST RECOVERY

11. Section **125.3** of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

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SIERRA VIEW DISTRICT HOSPITAL

12. From on or about October 26, 2009, until December 1, 2009, Respondent was employed as a registered nurse at Sierra View District Hospital (hereinafter "Sierra View") in Porterville, California.

13. On numerous occasions while employed at Sierra View, Respondent engaged in a pattern of unauthorized withdrawals of medication for the hospital's MedSelect[1] system, indicating that Respondent was diverting medication from the MedSelect for her own use, as follows:

a. October 26, 2009, at 20:47 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On October 26, 2009, at 20:49 hours, Respondent returned the medication to the MedSelect.

b. On October 29, 2009, at 01:51 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On October 29, 2009, at 01:52 hours, Respondent returned the medication to the MedSelect. On October 29, 2009, at 14:49 hours, pharmacy staff checked the MedSelect and noted that nine vials of diphenhydramine were missing.

c. On October 29, 2009, at 23:06 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On October 29, 2009, at 23:06 hours, Respondent returned the medication to the MedSelect. On October 30, 2009, at 06:22 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On October 30, 2009, at 06:22 hours, Respondent returned the medication to the MedSelect. On October 30, 2009, pharmacy staff checked the

[1] MedSelect is an automated system which tracks the withdrawal of medications.

MedSelect and found that only one vial had been returned to the MedSelect instead of the two that Respondent signed out and allegedly returned.

d. On November 1, 2009, at 04:40 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 1, 2009, at 04:41 hours, Respondent returned the medication to the MedSelect. On November 1, 2009, at 11:52 hours, pharmacy staff checked the MedSelect and found that nine vials of diphenhydramine were missing.

e. On November 3, 2009, at 15:29 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 3, 2009, at 15:55 hours, Respondent returned the medication to the MedSelect. On November 5, 2009, at 08:35 hours, pharmacy staff checked the MedSelect and found that five vials of diphenhydramine were missing.

f. On November 6, 2009, at 00:00 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 6, 2009, at 00:01 hours, Respondent returned the medication to the MedSelect. On November 6, 2009, at 02:17 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 6, 2009, at 02:17 hours, Respondent returned the medication to the MedSelect. On November 6, 2009, at 14:28 hours, pharmacy staff checked the MedSelect and found that seven vials of diphenhydramine were missing.

g. On November 8, 2009, at 19:29 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 8, 2009, at 19:29 hours, Respondent returned the medication to the MedSelect.

h. On November 11, 2009, at 02:08 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 11, 2009, at 02:08 hours, Respondent returned the medication to the MedSelect.

i. On November 15, 2009, at 22:56 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 15, 2009, at 22:56 hours, Respondent returned the medication to the MedSelect. On November 16, 2009, at 12:32 hours, pharmacy staff checked the MedSelect and found that nine vials of diphenhydramine were missing.

j. On November 17, 2009, at 02:23 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 17, 2009, at 02:23 hours, Respondent returned the medication to the MedSelect.

k. On November 21, 2009, at 00:22 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 21, 2009, at 22:31 hours, Respondent returned the medication to the MedSelect. On November 21, 2009, at 08:52 hours, pharmacy staff checked the MedSelect and found that four vials of diphenhydramine were missing.

l. On November 24, 2009, at 22:51 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 24, 2009, at 22:51 hours, Respondent returned the medication to the MedSelect.

m. On November 26, 2009, at 20:53 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 26, 2009, at 20:53 hours, Respondent returned the medication to the MedSelect. On

November 27, 2009, at 12:31 hours, pharmacy staff checked the MedSelect and found that nine vials of diphenhydramine were missing.

n. On November 27, 2009, at 06:46 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 27, 2009, at 06:46 hours, Respondent returned the medication to the MedSelect. On November 27, 2009, at 12:33 hours, pharmacy staff checked the MedSelect and found that five vials of diphenhydramine were missing.

o. On November 29, 2009, at 04:20 hours, Respondent removed one vial of diphenhydramine from the MedSelect. The patient for whom Respondent removed the medication did not have a physician's order for the medication. On November 29, 2009, at 04:20 hours, Respondent returned the medication to the MedSelect. On November 29, 2009, at 14:42 hours, hospital staff found that nine vials of diphenhydramine were missing.

14. On or about November 6, 2009, while Respondent was on duty as a registered nurse at Sierra View, Respondent was observed to display objective indications that she was abusing diphenhydramine. Respondent was observed to suddenly fall asleep while she was in the middle of reporting to another nurse about the condition of a patient.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

15. Respondent is subject to disciplinary action under section 2761(a) of the Code in that she acted unprofessionally, as set forth above in paragraphs 12-14.

SECOND CAUSE FOR DISCIPLINE

(Unlawfully Obtaining And Using Dangerous Drugs)

16. Respondent is subject to disciplinary action under section, 2761(a) and 2762, subsections (a) and (b), of the Code, in that she unlawfully obtained and possessed diphenhydramine, and dangerous drug, and used said drug, and so used it to an extent or in a manner dangerous or injurious to herself, any other person and/or the public, and the extent that

such use impaired her ability to conduct with safety to the public the practice authorized by her license, as set forth above in paragraphs 12-14.

THIRD CAUSE FOR DISCIPLINE

(Falsification Of Medical Record)

17. Respondent is subject to disciplinary action under sections 2761(a) and 2762(e) of the Code in that she falsified and/or made grossly I incorrect or unintelligible entries in hospital records pertaining to dangerous drugs, as set forth above in paragraphs 12-14.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 491867, issued to Lisa Renee Allen, aka Lisa Renee Pettit, aka Lisa Todd, aka Lisa Rock;

2. Ordering Respondent to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: June 6, 2012

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant